A Safeguarding Adult Review (SAR) in Rapid Time – Systems Findings Report template

A SAR commissioned by Suffolk Safeguarding Partnership

Following the death of Nigel , the Suffolk Safeguarding Partnership (SAB) arranged for the conduct of a Safeguarding Adult Review (SAR).

The SAB is collaborating with the Social Care Institute for Excellence to develop a new process to enable learning to be turned around more quickly than usual through a SAR. This new process is referred to as a SAR In-Rapid-Time.

What is a SAR In-Rapid-Time?

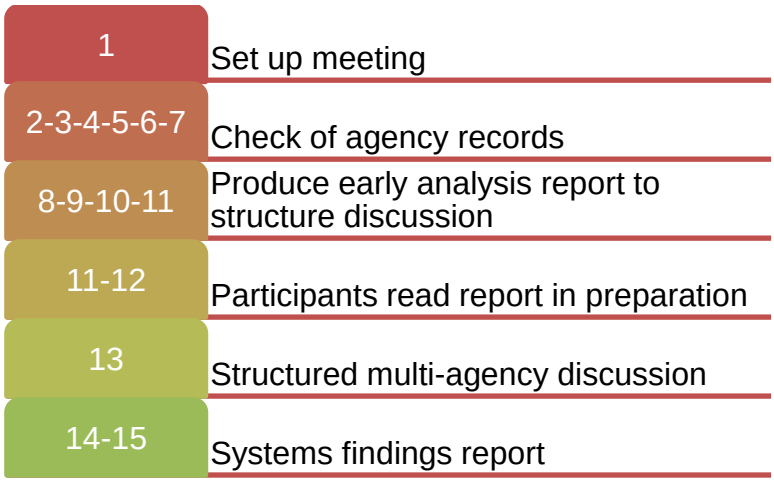
A SAR in Rapid Time aims to turn-around learning in an approximately 3-6 week timeframe, following the Set Up meeting. The Set-Up meeting is held after the decision has been made to progress with a review. An outline of the process is captured below.

The learning produced through a SAR in Rapid Time concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to do a good job day-to-day, within and between agencies.

Standardised processes and templates support an analysis of a case to identify systems findings in a speedy turnaround time.

The process is supported by remote meeting facilities and does not require any face-to-face contact.

Figure 1: Outline of a SAR In-Rapid-Time



This document

This document forms the final output of the SAR in Rapid Time. It provides the systems findings that have been identified through the process of the SAR. These findings are future oriented. They focus on social and organisational factors that will make it harder or easier to help someone in circumstances such as Nigel and his sisters found themselves, in a timely and effective manner. As such, they are potentially relevant to professional networks more widely.

In order to facilitate the sharing of this wider learning, the case specific analysis is not included in this systems findings report. Similarly, an overview of the methodology and process is available separately.

Each systems finding is first described, then one or more recommendations follow for each system finding. Additional learning from this SAR in Rapid Time is shown in Appendix A.

It is important to state that the quite brief time period on which this SAR focusses – from 11th January until 23rd February 2021 – occurred whilst the UK was responding to the Delta variant of Covid-19. England had been placed in tier 4 restrictions on 6th January 2021 and these restrictions began to be lifted from 8th March 2021. The SAR has been advised that during this period services were coping with high levels of staff absence and increased acuity in patients who became ill with Covid-19.

Nigel

Nigel was born in Yorkshire and moved to Suffolk with his family in the 1980's. His father was employed as a gardener and his mother worked in a bar. Nigel attended a school for children with additional needs. It is understood that Nigel has never been in employment, lived away from home or been in a relationship. Following the deaths of his father and subsequently his mother, Nigel and his sisters Emma and Penny continued to live together in the privately owned property in which they had resided with their parents. Their mother passed away three years before Nigel's death and it is understood that she had been an important figure in the lives of her adult children and that the loss of their mother may have had a significant emotional impact on the siblings and that they may have struggled to manage household tasks independently thereafter.

Nigel enjoyed watching TV - especially sport - and supported Liverpool football club. He said that his favourite player was the 'Egyptian one' (Mo Salah). He doesn't appear to have had any other interests or hobbies or to have had friends outside the family. It is understood that Nigel had been able to mobilise with the assistance of a walking stick but the extent to which was able to care for himself is unclear. Whilst he was aware of the painful and distressing condition of his legs, he was unable to give the Consultant Liaison Psychiatrist - who reviewed him during his hospital admission – a clear account of why help was not accessed. His sisters managed all his money matters (having LPA for 'property and financial affairs'), shopping and household tasks. Nigel and his sisters are believed to have kept to themselves and generally not sought support from any health or social care services. Nigel had very limited contact with his GP practice for many years.

Nigel had a diagnosis of spinocerebellar disease, spastic paraplegia, club foot and learning disability. He was also morbidly obese. Approximately 6 - 8 weeks prior to his hospital admission Nigel began to sleep downstairs in his chair as he was no longer able to climb the stairs and was using the kitchen sink for his toileting needs. He rarely bathed prior to this but during this period he became particularly unkempt. At the time

he was admitted to hospital, Nigel had wounds to both legs, a significant infection and cellulitis in both feet.

As stated, Nigel was examined by a Consultant Liaison Psychiatrist who concluded that he lacked the capacity to look after his physical health and that the likeliest reason for this was a learning disability of mild to moderate severity. Nigel reported periods of low mood and anger and had presented with agitation during his hospital admission. The extent to which this was situational is not known.

Prior to Nigel's discharge home from hospital, services began to engage with his sisters and gained access to the family home which was found to be very unhygienic and cluttered. The sisters were felt to lack insight into their living conditions and appeared to lack motivation to make the changes considered necessary to facilitate Nigel's return home. Initial concerns that the sisters may have wilfully neglected Nigel's care prior to his hospital admission began to diminish. However, the sisters, whilst unfailingly polite, were resistant to engagement with services and may have felt somewhat overwhelmed by the level of support being offered.

It has not been possible to engage with Nigel's sisters within the timescales allowed for a SAR in Rapid Time. The social worker who supported the sisters following Nigel's death attempted to facilitate this engagement but when she contacted the sisters to explain the purpose of the SAR and ask them if they would like to contribute, the social worker became aware that one of the sisters was unwell and arranged for her admission to hospital. At the time of writing, this sister remains in hospital with no discharge date having been set as yet. The SAB may wish to ask the independent reviewer to engage with the sisters when both are well again.

The SAB has expressed concern that the understanding of Nigel's lived experience has largely been gained from his contact with professionals, and principally whilst in the unfamiliar hospital environment. Engagement with Nigel's sisters would provide an opportunity to obtain much greater insight into his history and his lived experience. The independent reviewer has contacted the national SAR reviewers network to enquire about good practice in the area of understanding lived experience. Two SABs have commissioned advocates to write non-instructed advocacy reports on the people who were the subject of SARs (Hampshire and Surrey). The advocates gathered information by speaking to those who knew the person best and also attended the learning events where their input was said to have 'brought the person into the room'. Additionally, the advocates were able to challenge participants to think about the impact of their decisions upon the person who was the subject of the SAR. It is understood that one of the SAR advocates has written an article about this approach which may be published in the Journal of Adult Protection in due course.

Visit to meet Penny and Emma – Nigel's sisters

Meeting with Penny and Emma on 11 November 2022 at their home. The purpose of the visit was to explain to them that the Suffolk Safeguarding Partnership had undertaken a SAR to consider if agencies could learn from the sad death of their brother Nigel.

In the words of Penny and Emma.

Nigel was a very quiet person and that he would not tell people what he was thinking or if he was unwell.

Emma recalled that Nigel had gone downhill after their Mum passed away. However, in the months leading up to his hospital admission he had stopped caring for himself and wouldn't allow his sisters to support him.

The findings of the SAR were discussed with Emma and Penny.

They were surprised that the GP did not have Nigel recorded as having a learning disability and disappointed that he had missed out on annual Health checks.

When Nigel was discharged from hospital he arrived home with no frame, dressed in a hospital gown and looking very unkempt. She said that they dumped him in the front room and left him without any communication with her about his needs. Emma and Penny said that no one had come to assess Nigel at home or spoken to them about what his needs were. They did not feel that Nigel was actually "medically fit" from his presentation when he got home, and they were not part of the discharge process.

They also said they were disappointed with the care that was provided

Neither Penny or Emma were spoken to about the concerns raised that Nigel was being neglected or not able to care for himself. They did not know there were safeguarding concerns and did not have an opportunity to talk through with any professional/s.

While Penny was very poorly in hospital. Nigel had been in his chair all day sleeping but that was not unusual. It wasn't until the carer woke her and said Nigel was unresponsive that Emma was aware that he was unwell.

Systems findings

FINDING 1. GP practices may not be aware of all their patients with a learning disability diagnosis which means that those patients are will not benefit from the annual health check to which they are entitled. The absence of the annual health check is a variable significantly associated with premature death in people with a learning disability.

Systems finding

Nigel was not identified by his GP practice as having a learning disability diagnosis. A consequence of this was that Nigel was not offered the annual health check to which all people with a learning disability over the age of 14 are entitled. Nigel's GP practice advised the SAR that they conducted an audit of their patient records three years earlier in an effort to ensure that all patients with a learning disability were identified. This audit did not highlight Nigel. However, Nigel's GP practice records indicated - in the language of earlier times - that he had a 'mental handicap', which begs the question of how effective the audit methodology was. In a safe system all patients with a learning disability diagnosis would be identified by their GP practice so that they receive an annual health check. In Nigel's case, the annual health check would have allowed the GP practice to get to know Nigel better, to identify and address any health problems earlier and may have helped to prevent the steep decline in Nigel's health which preceded his hospital admission.

The life expectancy of people with a learning disability is much lower than that of the general population and not having an annual health check in the year prior to death is one of a small number of variables significantly associated with a greater likelihood of a person with a learning disability dying aged 18-49 years (1) (Nigel was 51 at the time of his death).

The NHS Long Term Plan (2) states that ‘action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people’ and commits to improving uptake of the existing annual health check in primary care for people with a learning disability, so that at least 75% of those eligible have a health check each year.

Lack of recognition of learning disability by GP practices was a prominent finding of two 2015 SARs commissioned by Suffolk SAB (‘Amy’ and ‘James’), and in response to a recommendation to develop and promote specific guidance for primary care services about annual health checks for people with learning disabilities, the SAB committed to ‘developing a ‘Model of Best Practice’ around the use of annual health checks for people with learning disabilities through the SAB Health Sub Group. It has not been possible to ascertain the outcome of this work.

However, the SAR has been advised that the Learning Disability Steering Group has an ongoing programme of work to improve GP LD Registers and access to annual health checks, including the identification of annual health check (AHC) GP Leads within CCGs and the establishment of a Learning Disability lead within each GP practice; the development of a local dynamic risk register, integral to which is a local Learning Disability Register ‘deep dive’ – for which NSFT have recruited a member of staff; review and data cleanse of GP LD registers with primary care; NSFT and social care registers coordinated by primary liaison team with additional focus on the 14+ cohort; promotion of the LD Register to people with LD and their family, with easy read resources explaining LD registers including through schools; a focus at the LD weekly well-being session run by the Peer Educator Network on the purpose of the LD register and how to be 'flagged'; ongoing promotion within primary care of the importance of AHC for people with a learning disability, ongoing promotion to primary care to spread AHC across the year, with invitation linked to birthday.

It is beyond the scope of this SAR to analyse the likely effectiveness of this programme of work, but it appears to be a comprehensive and serious response to the system weakness identified by this SAR.

During his hospital admission professionals eventually concluded that Nigel had a learning disability and the hospital advised his GP practice to add him to their register of patients with a learning disability, which they did. The information held on Nigel by the Suffolk and North East Essex Health Information Exchange (HIE) was instrumental in establishing that he had a learning disability. The HIE is an innovative project which has brought together patient information from acute hospitals, primary care and adult social care and will be expanded to included mental health providers shortly. Not all professionals who contributed to this SAR appeared to be aware of the HIE.

The SAR has also been advised that on 24th November 2020 (seven weeks prior to Nigel’s hospital admission) the GP practice were unable to contact Nigel by phone or text after receiving a request (source of request not documented) for new orthotic boots. When the ambulance service attended Nigel’s address and conveyed him to hospital on 11th January 2021 they noted that he was wearing ‘built up shoes that have collapsed’. The extent to which the poor state of Nigel’s orthotic boots contributed to his inability to ascend the stairs to access his bedroom and use the bathroom is not known. Given the fact that Nigel’s GP practice records indicated that he had a ‘mental handicap’, the GP practice could have considered whether he may have had communication difficulties and whether a reasonable adjustment should have been made such as considering alternative methods of communication such as making a home visit.

Recommendations or considerations:

- It is recommended that the learning from this SAR is used to inform the programme of work being overseen by the Learning Disability Steering Group, in particular the effectiveness of methodology used to audit GP patient records in an effort to identify patients with a learning disability.
- It is recommended that the NHS Clinical Commissioning Groups for Ipswich and East Suffolk and for West Suffolk seek assurance that GP practices make reasonable adjustments when communicating with patients who may experience difficulties in communicating.

FINDING 2. Patients in respect of whom there is a Section 42 Safeguarding Enquiry are being discharged home from hospital without a multi-disciplinary discharge planning meeting taking place.

Systems finding

Nigel was discharged home from hospital without a multi-disciplinary discharge planning meeting taking place. The hospital was aware that safeguarding referrals made at the time of Nigel's hospital admission by the East of England Ambulance Service (EEAS) and East Suffolk and North Essex NHS Foundation Trust (ESNEFT) were subject to a Section 42 Safeguarding Enquiry which had not yet been completed.

Within a safe system, when a patient is admitted to hospital from their home address and their home circumstances give rise to safeguarding concerns which remain unresolved by the time the patient is medically fit for discharge, a multi-disciplinary discharge planning meeting would take place. The discharge planning meeting would consider whether it was safe to discharge the patient back to their home address and, if safeguarding risks remained, how those risks would be mitigated.

However, a major change to the discharge of patients from hospitals was introduced in March 2020 in order to free up hospital beds to respond to the first wave of the pandemic. At the heart of that change is the 'discharge to assess model' under which acute and community hospitals are required to discharge all patients as soon as it is clinically safe to do so and community health services are required to assess and provide care for patients who require input from health and/or social care, *once they are home.* There appears to be a potential tension between the 'discharge to assess' model – with its emphasis on rapid discharge once it is *clinically* safe for the patient to be discharged - and the importance of addressing any safeguarding risks the discharged patient may be exposed to in their home environment.

The 'discharge to assess' model also envisages that a lead professional or multidisciplinary team will visit the patient at home on the day of discharge or the day after to assess what support is needed in the home environment and rapidly arrange for that to be put in place. No-one appeared to be identified as a 'lead professional' in Nigel's case nor did there appear to be a formal assessment of support needs in the home environment 24 or 48 hours after discharge. However, in Nigel's case, arrangements had been made for home support to be put in place in the period prior to discharge.

This SAR has been advised that the ESNEFT Safeguarding team have contributed to a project overseen by the Senior Matron to review patient paperwork. It is intended that patient paperwork will have a section for safeguarding concerns to be documented so that it is explicitly clear whether concerns have been raised and whether they have progressed to a Safeguarding Enquiry. This is a welcome step, but this alone may not

ensure that a multi-disciplinary discharge planning meeting takes place as there is no doubt that the hospital was aware of the Safeguarding Enquiry at the time of Nigel's discharge from hospital.

A Best Interest meeting should also have been considered prior to discharge as, in a referral from the ward to the discharge to assess unit, it was documented that it was felt that Nigel lacked the capacity to make decisions relating to discharge. There was no indication that a Best Interest meeting took place.

Families' perspective and views:

See above.

Recommendations or considerations:

- It is recommended that ESNEFT amend their discharge planning arrangements to suggest a multi-disciplinary planning meeting where the patient is subject to an ongoing Section 42 Safeguarding Enquiry and there is suitable reason to call and MDT to further protect that person (e.g. in Nigel's case he was returning home to place of risk).

FINDING 3. People subject to a Section 42 Safeguarding Enquiry are not having their need for a protection plan reviewed when they move from one setting to another

Systems finding

There was no protection plan in place when Nigel returned home following his discharge from hospital. When a strategy meeting was convened to consider the EEAS and ESNEFT safeguarding referrals and a Section 42 Safeguarding Enquiry commenced, it was decided that a protection plan was unnecessary as Nigel was in hospital. However, no protection plan was put in place when Nigel returned home following his hospital discharge. Had a multi-disciplinary discharge planning meeting taken place prior to Nigel's discharge, this may have led to a protection plan being prepared. However, the Suffolk Council Learning Disability and Autism Specialist Support Team, which was conducting the Section 42 Safeguarding Enquiry, was aware of Nigel's discharge and did not put a protection plan in place.

Included in the 'next steps' agreed at the aforementioned strategy meeting was 'risk prevention to prevent further harm'. The 'danger statement' stated that 'the Specialist Support Team are very worried that you have been ill for some months and that no-one called your GP for assistance'. In a safe system, a protection plan would have been the key mechanism for clarifying and addressing risks to Nigel. The protection plan would also have been the mechanism for highlighting new risks which arose when Hospital Occupational Therapy visited the home address and found it to be 'very dirty, smelly and cluttered' and formed the view that 'there was an element of self-neglect for all members of the household', when Lofty Heights received only limited co-operation from Nigel's sisters when they attempted to clean the house and create space for a bed and commode on the ground floor, when Nigel's sisters quickly reduced Home First's daily visits from 4 to 2, when the district nurses became concerned that Nigel was presenting with Covid-19 symptoms four days before he died and when the ambulance service conveyed one of Nigel's sisters (who was also a carer for Nigel) to hospital with Covid-19 three days before he died.

Practitioners appeared to have different perceptions of what constitutes a protection or safety plan. Some practitioners viewed the support put in place at the time of Nigel's

discharge from hospital as the 'safety plan', which was echoed to an extent in the Section 42 Safeguarding Enquiry report which described the support provided by Home First as a 'safety net'.

Had a protection plan been in place it seems very unlikely that the ambulance service would have been aware of it when they attended Nigel's address and conveyed one of his sisters to hospital with Covid-19 just three days before Nigel himself died of Covid-19. Although EEAS has only been able to locate very brief details of this ambulance attendance, they have confirmed that the crew noted that Nigel and his other sister were also present at the address. It is not known whether the crew spoke to Nigel. Had the crew been aware of a protection plan, they would have been aware of the risks to Nigel and would have been able to deduce that the risks he faced could increase if one of his sisters was no longer available to care for him. The safety of the system could be enhanced if it was possible to share protection plans with a wider range of services including the EEAS and primary care.

Families' perspective and views:

See above.

Recommendations or considerations:

- It is recommended that Adult and Community Services put a system in place to trigger reconsideration of protection planning when a person who is subject to Section 42 Safeguarding Enquiry transfers to a different setting.
- It is recommended that consideration is given to developing a system for sharing protection plans with all agencies having a legitimate reason to be aware of the protection plan and its contents.

FINDING 4. The case closure process for Section 42 Safeguarding Enquiries does not include an adequate process for considering whether a Safeguarding Adults Referral is justified.

Systems finding

Within a safe system, the closure of a Safeguarding Adults Enquiry would be recognised as an opportunity to consider whether a referral for consideration of a Safeguarding Adults Review was justified. Safeguarding Adults Reviews provide an opportunity for improvements to systems to be made which could prevent people suffering abuse or neglect in the future.

In Nigel's case the Safeguarding Adults Enquiry was closed in April 2021 following his death in February 2021 without a referral for a Safeguarding Adults Review apparently being considered. The rationale for closure of the case stated that 'support was put in place which reduced the risk (though home circumstances were not the most hygienic)'. This was not an accurate summary of the case.

The case closure form includes the question 'Was a Safeguarding Adults Review held?' which was answered 'no'. The question 'Should a Safeguarding Adults Review be held?' is not included in the case closure form. Including this additional question would require consideration of whether the criteria for considering a Safeguarding Adults Review may have been met.

It was only when the LeDeR initial review report was completed in August 2021 that the concerns which led to a referral for a Safeguarding Adults Review referral were highlighted.

Families' perspective and views:

See above

Recommendations or considerations:

- It is recommended that the process for closing Section 42 Safeguarding Enquiries is enhanced to specifically consider whether a referral for a Safeguarding Adults Review referral is justified.

Overview of findings:

FINDING 1. GP practices may not be aware of all their patients with a learning disability diagnosis which means that those patients are will not benefit from the annual health check to which they are entitled. The absence of the annual health check is a variable significantly associated with premature death in people with a learning disability.

FINDING 2. Patients in respect of whom there is a Section 42 Safeguarding Enquiry are being discharged home from hospital without a multi-disciplinary discharge planning meeting taking place.

FINDING 3. People subject to a Section 42 Safeguarding Enquiry are not having their need for a protection plan reviewed when they move from one setting to another.

FINDING 4. The case closure process for Section 42 Safeguarding Enquiries does not include an adequate process for considering whether a Safeguarding Adults Referral is justified.

References

(1) Retrieved from http://www.bristol.ac.uk/media-library/sites/sps/leder/Repository%20Analysis%202018%20-%202019.pdf

(2) Retrieved from https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/learning-disability-and-autism/

Appendices

Appendix A

Additional learning from this case:

Progress of the Section 42 Safeguarding Enquiry

The single agency Section 42 Safeguarding Enquiry was initially allocated to FCST East on 21st January 2021 but later re-allocated to the Learning Disability and Autism

Specialist Support Team when it was established that Nigel had a learning disability diagnosis. 'Suggested next steps' at the time of the strategy meeting included 'face to face assessment to gather Nigel's wishes and views', 'consider advocacy' and 'consider carer's assessments'. A 'face to face assessment' would probably have needed to wait until Nigel was discharged home as social workers were not visiting patients in hospital at that time, but no assessment had been completed prior to Nigel's death apart from Home First's assessment of Nigel's reablement potential, no advocate had been instructed and no carers assessments had been initiated.

Self-Neglect

The possibility that Nigel's presentation at the time of his hospital admission could be the result of self-neglect - or a combination of carer neglect and self-neglect - appeared to be overlooked for a time. When professionals began to engage with Nigel's sisters in preparation for his discharge from hospital, indications that hoarding may also be an issue began to arise.

Legal literacy

The plan to consider an offence under Section 44 of the Mental Capacity Act (MCA) should there be evidence of wilful neglect by Nigel's sisters had the unintended consequence of causing quite prolonged confusion amongst professionals from a range of disciplines. Some professionals incorrectly regarded Section 44 MCA as an alternative to Section 42 of the Care Act.

Learning Disability Diagnosis

The discussion over whether Nigel had a learning disability appeared to be unnecessarily prolonged and continued after it had been established that he did have a learning disability diagnosis.

Escalation of concerns

On Friday 19th February 2021 the district nurse made determined efforts to escalate concerns about Nigel who was presenting with Covid-19 symptoms and whose sisters were ill in bed. The responses she received from Nigel's GP practice and subsequently from Customer First were insufficient and had the effect of de-escalating the district nurse's concerns. The district nurse created a full entry on System One in sufficient time for the GP practice to read the entry and add Nigel to the morning home visits list. (The District Nurse and GP Practice access to System One is noted to be a system which should make it easier for professionals do a good job). The recording of the call the District Nurse made to Customer First has been listened to and the response by the call handler is considered to have fallen below expected standards. The placement team should have been approached about possible additional care – and not just Home First – and the concerns about Nigel should have been escalated to the social worker on call (The District Nurse's call to Customer First was out of hours). It will be necessary to remind call handlers of the need to look thoroughly at history, open safeguarding enquiries and the types of issues it is necessary to raise with social workers.

Mental Capacity Act 2005 Assessments

Shortly after his hospital admission a reasonable adjustment tool found that Nigel could understand decisions he was asked to make using simplified terms. He was later assessed to 'have capacity' by the Hospital Mental Health Liaison Team. In a referral

from the ward to the discharge to assess unit it was documented that it was felt that Nigel lacked the capacity to make decisions relating to discharge. However, there was no indication that a Best Interest meeting took place. The assessment by the Consultant Psychiatrist implied that Nigel lacked executive capacity to look after his physical health.

Engagement with Nigel's sisters

After the sisters had initially demonstrated a reluctance to engage with services, an accommodation of sorts appeared to have been arrived at where Home First were visiting Nigel twice daily and the District Nurses were visiting every four days. Had one of the sisters and then Nigel not contracted Covid-19, there appeared to be an opportunity to gradually increase trust and confidence and gain a better understanding of the dynamics of the relationship between Nigel and his sisters and the impact on them of the death of their mother.

Tracking of families where adult children may struggle due to physical or mental health issues when they are pre-deceased by their parents

Is this something which could be considered? Could Nigel's mother's death have been perceived as the loss of a protective factor in her adult children's lives and their support needs considered at that stage?